



National Association of State EMS Officials

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NASEMSO Issue Brief on the Repeal of Emergency-Response Provisions Contained in the Ryan White Care Act

Issue

During the recent reauthorization of the Ryan White Care Act in 2006, the emergency-response provisions were struck by Congressional staff members representing the key members of the committee with jurisdiction. Because the primary purpose of the Ryan White Law is to provide funding for HIV programs in the country and none of the staffers participating in the reauthorization discussions understood the purpose of the emergency-response provisions of the law, the emergency response provisions were deleted from the reauthorization bill.

NASEMSO Position

The National Association of State EMS Officials supports the efforts of Congressman Henry Waxman and others to reauthorize the emergency response provisions contained in the original Ryan White Care Act (P.L. 101-381) that mandates that source patient test results be provided to the designated infection control officer (DICO) of the emergency response employee involved in an exposure incident and encourages revised language to include provisions for hepatitis C, pandemic influenza, and clarifying language on rapid testing.

Rationale and Background

Ryan White was a 13 year-old hemophiliac from Indiana when he was inadvertently infected with HIV/AIDS during a blood transfusion in the 1980's. Shortly after his death in 1990, Congress passed the Ryan White Care Act, intended to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease. The Act was reauthorized in 1996, 2000, and 2006 and remains an active piece of legislation today. The Ryan White programs also funds and provides technical assistance to local and state primary medical care providers, support services, healthcare provider and training programs.

Workers in many different occupations are at risk of exposure to bloodborne pathogens, including Hepatitis B, Hepatitis C, and HIV/AIDS. Emergency medical services (EMS) personnel are healthcare providers who may be at risk of exposure to blood and other body fluids when caring for victims of trauma but also in the handling of used needles and syringes, secretions, and other body fluids while caring for all types of patients. In 1991, OSHA issued the Bloodborne Pathogens Standard ([29 CFR 1910.1030](http://www.federalregister.gov/doc/56266/29-cfr-1910.1030)) to enhance worker protection from this risk.

When emergency response personnel are exposed to potentially infectious body fluids, a key provision of the Ryan White Care Act mandates that source patient test results be provided to the designated infection control officer (DICO) of the emergency response employee involved in an exposure incident. The medical facility to which the source patient involved in the exposure was transported HAD the legal obligation under this law to provide source patient test results following notification of the exposure by the DICO. The DICO then has the obligation to inform the exposed employee of the source patient test results.

The OSHA Bloodborne Pathogens Standard provides that the employer of an employee involved in an exposure incident must obtain the results of the source individual's testing and make this information available to the exposed employee. However, the Ryan White Law provided the legal provisions necessary to force hospitals to comply with the request for testing and release test results to the designated officer. The provision in the Ryan White Law also gave emergency-response employers the right to contact the Centers for Disease Control and Prevention (CDC) and request that they intervene when hospitals refused to comply with the law.

Key Questions and Answers

What are the risks for EMS personnel for exposure to infectious materials in the workplace?

Virtually every patient encounter contains the risk of exposure to infectious materials for EMS personnel. While advances have been made to protect workers from blood and other body fluids, the prehospital environment is frequently chaotic and inadvertent exposure can occur when blood and other materials splash or splatter onto EMS workers and are inadvertently ingested, absorbed, or inhaled. Exposure can also occur when blood from the source patient seeps into any cut that rescue workers may sustain during vehicle extrication or inadvertent "needle stick" if a patient becomes combative during invasive medical procedures or a needle is accidentally dropped or lost in clothing, bedding, or otherwise. There are also reports of EMS personnel being "stuck" when dirty needles puncture the plastic receptacles intended to protect them from harm.

Isn't OSHA's Bloodborne Pathogens Standard sufficient to protect emergency response workers from exposure to infectious materials?

No. OSHA does not have jurisdiction over state and local governments in about half of the states. In addition, the bloodborne pathogens standard does not provide a clearly stated post-exposure procedure to be followed and does not give clear timeframes for testing and notification. Finally, OSHA does not provide the clear coverage of volunteers that the Ryan White law provided.

What other provisions of the Ryan White law are important to EMS personnel?

The Ryan White law also requires mandatory training/education and mandatory infection control safety programs at the agency/employer level.

Why are the emergency-response provisions of the Ryan White law so critical to the safety of EMS personnel?

The emergency-response section of the Ryan White law put emergency responders in charge of post-exposure management instead of medical facilities. The Ryan White law requires all emergency response employers—fire departments, police departments, and EMS agencies in the country to have a "designated infection control officer." The law stated that if an exposure to communicable diseases

occurred, the infection control officer of the employer of the exposed emergency responder must contact the medical facility to which the source patient in the exposure was transported and request their disease status. It forced hospitals to cooperate with emergency response agencies in post-exposure treatment.

Couldn't an emergency responder find other legal means to obtain a source patient's disease status following an exposure?

It would be enormously difficult for an individual emergency responder to request this type of information from a medical facility. The Health Insurance Portability and Accountability Act (HIPAA) has made it virtually impossible to obtain any patient information without the patient's consent—even if, in a worst case scenario, the source patient knows they are infected with a serious disease and knowingly tries to infect an emergency responder by biting, spitting, or other means. Under the Ryan White law, the medical facility had the obligation to provide results as soon as possible and no later than 48 hours of the request. This rapid testing and quick turnaround of disease-status information has been critical in effective post-exposure medical management. It also allowed department personnel to be tested if needed and treated outside of the emergency department, which served to lower costs and increase proper care and counseling.

Were there any other mandates supported by the emergency response provisions?

The law also provided that medical facilities were required to contact the designated infection control officer of any emergency response employer that transported a patient with pulmonary tuberculosis as soon as possible and no later than 48 hours of making that medical determination.

Another provision allowed for an injunction to be imposed onto non-compliant hospitals, which could mean a stop to federal money going to that facility. Although that provision never needed to be used, the threat of an injunction was sufficient to encourage compliance.

Why is clarification needed to support "rapid testing" by medical facilities?

Rapid tests are now available that can give us the disease status (such as HIV) of source patients within a few hours and current CDC guidelines instruct labs to conduct testing in this manner. Rapid testing reduces the need to provide emergency responders with prophylactic medication that is expensive and contains a risk of toxic side effects.

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Cross JR (2008) Emergency Response Provisions of Ryan White Law Repealed. J Emer Med Serv. Mar; 33(3): 136-137.